

1 Q Okay. Trust me when I say that our office  
2 understands that prisoners can be a litigious  
3 bunch. Other than these instances and the one you  
4 mentioned, have you ever been sued for malpractice  
5 before?

6 A In my private practice, I have never other than the  
7 one, that vicarious liability. For work that I  
8 have done, I have never been sued.

9 Q Okay. Okay. It is my understanding that you began  
10 consulting for the Massachusetts Department of  
11 Correction in or around 2007, is that correct?

12 A Yes.

13 Q And it's my understanding that what happened is  
14 that you were initially appointed by a court to  
15 evaluate a prisoner seeking gender-affirming care,  
16 and on the basis of the relationships you developed  
17 in that case, the Massachusetts Department of  
18 Correction made your role a more permanent  
19 consultancy. Is that a fair summary?

20 A It's about 90 percent accurate, but let me --

21 Q Sure.

22 A Let me give it to you more accurately. The judge,  
23 the federal judge, asked me to be his witness in a  
24 case in 2006, and so I did that. After that case,  
25 after my six hours on the stand -- I don't

1 remember -- several months later the Massachusetts  
2 prison -- the DOC in Massachusetts reached out to  
3 me, and they had 12 prisoners in various  
4 institutions, and they sent -- they asked for a  
5 consultant for those 12 prisoners with transgender  
6 identities, and the consultations on the 12  
7 prisoners came back with the same 12  
8 recommendations, which is they should immediately  
9 have sex reassignment surgery. And so the DOC was  
10 outraged at this, and they hired me to come to  
11 Massachusetts and interview those prisoners and  
12 give them an individualized treatment plan for 12  
13 people. In the process of doing that, I suggested  
14 to them that they needed to have a gender identity  
15 clinic. They needed to take care of these  
16 prisoners, not on a one-time consultation basis,  
17 but they needed to provide evaluation and therapy  
18 for their trans prisoners.

19 And so they agreed to do that. And in order  
20 to do that, they invited me to, on my suggestion,  
21 that I gave a six-hour workshop to the mental  
22 health faculty of the staff of the prisoner system.  
23 And so one day all these people came into the  
24 audience, and I spent six hours talking to them  
25 about what was known about this phenomenon, and

1 they had volunteers from each of their male prisons  
2 to be in the new Gender Identity Clinic there. And  
3 I was appointed the consultant to that clinic, and  
4 in the course of years there -- and that would be  
5 going on the 17th or 18th year -- I have sort of  
6 educated not only their staff, but I have educated  
7 their psychiatric directors, so there have been  
8 three psychiatrists, three people, who directed  
9 those clinics. And over the years, I have played a  
10 role in educating them and overseeing their work,  
11 and my oversight is very minor, generally, because  
12 I go to a -- I spend two hours once a month during  
13 their meetings and comment on their cases and try  
14 to get people up to speed in terms of understanding  
15 the complexity of the mental lives of prisoners.

16 Q Okay.

17 A That's my role.

18 Q You still serve in that capacity as a consultant to  
19 the Massachusetts DOC?

20 A Yes, I do.

21 Q Okay. It sounded like before your involvement  
22 these 12 prisoners had all been approved for  
23 gender-affirming surgeries?

24 A Oh, no, no, no, no, no. Quite the opposite. They  
25 were recommended for sex reassignment surgery by

1 people who didn't work in the prison, and that  
2 horrified the prison system.

3 Q Okay. So they had been recommended by outside  
4 providers to receive gender-affirming surgery?

5 A Yes. On the basis of one-to-two-hour visits.

6 Q Okay. And did the Massachusetts DOC ask for you to  
7 reevaluate these patients?

8 A That's exactly what they asked me to do, yeah.

9 Q Did they ask for you to reach a conclusion about  
10 whether each of them was appropriate to receive  
11 gender-affirming surgery?

12 A They asked me to create a plan, a treatment plan.  
13 They actually thought that none of these people  
14 were appropriate for surgery because it wasn't --  
15 it wasn't part of the general zeitgeist in those  
16 days in prison systems to provide surgery.

17 Q And of the -- and I assume you -- I'm sorry. I  
18 assume you completed treatment plans for all 12  
19 individuals?

20 A I did.

21 Q And of the 12 treatment plans you created, did any  
22 of those treatment plans conclude or recommend that  
23 surgery was appropriate or otherwise recommend  
24 surgery?

25 A Surgery was a possibility in the future.

1 Q For all 12 of them?

2 A Well, you know, one of them was near death, you  
3 know. There were 12 different people with 12  
4 different, you know, disturbed backgrounds, 12  
5 different histories. And, you see, the initial  
6 consultant said that if a person is currently  
7 gender dysphoric and wants surgery, they ought to  
8 have it. It was medically necessary.

9 Q Let me ask the question this way. In the 12  
10 treatment plans you created, did all of these  
11 treatment plans leave open the possibility that in  
12 the future the prisoners might be able to obtain  
13 surgery?

14 A Again, I said to you I don't have a crystal ball  
15 about the future. I would say the answer to that  
16 is likely to be yes. It left open the possibility  
17 if certain -- No. 1, if the law changed, if the  
18 person had psychotherapy, if the person -- if the  
19 doctors who are dealing with the person -- I should  
20 say clinicians dealing with the person had a really  
21 good sense of their developmental history and their  
22 ability to give informed consent, yes. Given the  
23 fashion that transsexual people outside prison are  
24 getting surgery, there was a possibility but not  
25 now and not on the basis of a one or two-hour

1 visit.

2 Q I understand that you may have and have consulted  
3 on individual cases for prison systems other than  
4 Massachusetts, but have you had the sort of ongoing  
5 role for any prison system other than  
6 Massachusetts?

7 A No. I have been to various prisons, to New Jersey  
8 and to Virginia and to California and to Washington  
9 State to consult on individual prisoners.

10 Q All right. And outside of Massachusetts,  
11 approximately how many gender dysphoric prisoners  
12 have you been asked to consult on?

13 A If you take the list that I just gave you and add  
14 one to that because in Washington I -- no. In  
15 Washington, over time on two different occasions, I  
16 think I was involved with three prisoners. And in  
17 Virginia, there was a -- there was one prisoner,  
18 and in New Jersey, there was a prisoner. In  
19 Florida, there was one prisoner. So, again,  
20 excluding Massachusetts where there's a huge number  
21 of prisoners, that would be it.

22 Q So it sounds like we're talking about maybe --

23 A California two, two in California.

24 Q So I am not going to hold you to a precise number,  
25 but it sounds like we're talking about six or eight

1 different prisoners?

2 A I would say eight would be the maximum.

3 Q Okay. And were these all in the context of  
4 litigation?

5 A No.

6 Q Okay.

7 A No, not at all. Well, some were.

8 Q Doctor, we're at just about 90 minutes right now.  
9 I'm happy to go for a couple more minutes to reach  
10 a more natural breaking point if you would like,  
11 but I also want to make sure I respect your request  
12 for a break every 90 minutes if you'd like to take  
13 a break now.

14 A I would, but it doesn't have to be a long break. I  
15 will be back in one minute, if you don't mind.

16 Q Well, I have to use the facilities real quick, so  
17 why don't we say three or four minutes.

18 A Okay. Very good.

19 Q Thank you very much, Doctor.

20 (A brief recess was taken.)

21 Q Doctor, of the -- before the break we were talking  
22 about individual cases where you had offered  
23 consultation concerning gender-affirming care  
24 provided to inmates. Do you recall that?

25 A Yes.

1 Q And in a number but not all of these cases -- or a  
2 number but not all of these cases arose in the  
3 context of litigation. Is that a fair statement?

4 A Yes.

5 Q Okay. In the cases where you have offered either  
6 an expert report or testimony concerning  
7 gender-affirming care to a prisoner, I assume in  
8 every single case it's been the relevant department  
9 of correction that's hired you?

10 A Yes. I think the Florida case was a private law  
11 firm, but maybe the department of corrections hires  
12 the law firm.

13 Q But you testified on behalf of the State in that  
14 case, is that fair?

15 A In Florida?

16 Q Yes.

17 A I'm not sure.

18 Q That's --

19 A You know, the legal context -- I keep learning  
20 about the legal context. I think the most honest  
21 answer is I'm not sure.

22 Q That's perfectly fair. The Florida case, is that  
23 the Keohane case? Do I have that right?

24 A Well, you're not pronouncing it right, but no one  
25 ever does, so, yes, that's right.

1 Q It's K-e-o-h-a-n-e.

2 A I think he pronounces it Keohane, but I'm not sure.

3 Q I was just spelling it for the court reporter, but  
4 I have the spelling right, correct?

5 A No. You -- that's right.

6 Q Okay. And in these cases, have you ever offered  
7 testimony that you believe that gender-affirming  
8 care was -- or gender-affirming surgery was  
9 appropriate for a prisoner?

10 A The Virginia case, which is not in the category  
11 that you're talking because I think Virginia just  
12 asked me what to do with this case, I just remember  
13 there was another California case that was not  
14 involved with litigation. I recommended that there  
15 was a pathway to surgery relatively soon, but then  
16 the patient got discharged from prison. The inmate  
17 got discharged.

18 Q And you're familiar, I assume, with the Koselik  
19 case in Massachusetts?

20 A Yes.

21 Q And did you offer testimony in this case that  
22 gender-affirming surgery would be appropriate for  
23 Ms. Koselik?

24 A No. In the testimony, I thought that the  
25 adequate -- there was adequate treatment, adequate

1 treatment for her gender dysphoria in the case with  
2 2006. Subsequently, I was on the committee that  
3 approved sex reassignment, vaginoplasty, for this  
4 person. And Koselik has been operated on now and  
5 is living in a female prison.

6 Q So as part of your role on that committee, you  
7 assisted in approving the surgery?

8 A Yes. I voted yes.

9 Q Okay. And when you began that answer, you said  
10 that -- I'm paraphrasing you -- but in 2006, you  
11 offered testimony that the care that she had been  
12 receiving was adequate?

13 A Yeah.

14 Q Did you misspeak there?

15 A No.

16 Q I thought it was my understanding that you offered  
17 whether or not concerning surgery at the outset you  
18 offered testimony that the care she was receiving  
19 was inadequate. Do I have that wrong?

20 A You have it wrong.

21 Q Okay. I apologize. You know that case better than  
22 I do, so I'm sorry for that.

23 A Well, we will hope so, but it was 2006.

24 Q That's fair. Prior to this litigation, have you  
25 ever provided consultation regarding an inmate

1 incarcerated with the Indiana Department of  
2 Correction?

3 A No.

4 Q Okay. Are you aware -- and you may not be -- that  
5 before the enactment of the statute that we have  
6 challenged in this case the Indiana DOC approved  
7 two different inmates to receive gender  
8 confirmation surgery?

9 A I became aware of that two days ago.

10 Q All right. And I assume you did not play any role  
11 in the evaluation of these two inmates?

12 A That's correct.

13 Q Okay. Okay. Have you ever personally administered  
14 any sort of psychometric or psychological testing  
15 to an inmate? I'm sorry. Not to an inmate. To a  
16 patient?

17 A I already told you that in the Case Western Reserve  
18 in our evaluation process over many, many years,  
19 these psychological tests were an integral part of  
20 the evaluation.

21 Q Sure.

22 A Yes. And did I -- maybe I misunderstood the  
23 question. You said did I ever, and the answer is  
24 repeatedly.

25 Q Okay. And I guess I was attempting to distinguish

1 between the clinic and you personally. Were you  
2 personally responsible for administering these  
3 tests?

4 A No. No. These tests are self-administered tests.  
5 The patient does it by themselves.

6 Q And the two tests you mentioned are known as the  
7 MMPI and the MCMI. Am I correct on that?

8 A Yes. They're all true/false questions.

9 Q Are those the only two psychometric tests that have  
10 been administered at the clinic to dysphoric  
11 patients?

12 A Generally speaking, yes.

13 Q And you say they're self-administered. These are  
14 tests where the patient is given a list of  
15 questions and answers them?

16 A Yes.

17 Q And are you personally responsible for interpreting  
18 or scoring the test results?

19 A No.

20 Q Who's responsible for that?

21 A Well, No. 1, the computer generates an  
22 interpretation, but we don't follow the computer.  
23 We take that into consideration, but we have an  
24 independent psychologist who is trained in the  
25 interpretation of these tests, and we get usually a

1 one-page report that combines -- when we do both  
2 tests, it combines the results of both of those  
3 tests.

4 Q And I assume that prior to the invention of  
5 computers the tests went directly to the  
6 independent psychologist to interpret?

7 A Yes.

8 Q So it sounds like you are not trained to interpret  
9 the results of these tests, is that fair?

10 A No. Like most psychiatrists, we don't undergo  
11 training for that.

12 Q Training on this particular issue. You're trained  
13 in other matters, right?

14 A Other matters, yes.

15 Q I was joking. Okay. Doctor, you're familiar, I  
16 assume, with the -- I'll just say the complete name  
17 once -- but with the Standards of Care for the  
18 Health of Transgender and Gender Diverse People  
19 that is published by WPATH, correct?

20 A Am I familiar with WPATH as an organization or --

21 Q Are you familiar with the standards of care that  
22 they publish?

23 A Yes.

24 Q And the current version is Version 8, which is  
25 sometimes referred to as SOC8, is that correct?

1 A Yes.

2 Q And my understanding is that you were involved in  
3 the drafting of Version 5 back when WPATH had its  
4 predecessor name?

5 A Yes.

6 Q Okay. And that was the version that came out in  
7 1999?

8 A Yes.

9 Q And you were the -- do I have the title right? You  
10 were the writing chair for that version?

11 A I was just the chair. I didn't have the term  
12 "writing chair," but I did the writing, right.

13 Q Did you write the entire Version 5 or significant  
14 portions of it?

15 A I wrote significant portions of it. And, for  
16 example, George Brown wrote the part -- the section  
17 on prisoners, but I integrated everyone's writings,  
18 you know, into one writing style, and it was my  
19 writing style.

20 Q And I assume you approved every single word before  
21 it was released?

22 A Yes.

23 Q Okay. Is that the only version of the WPATH  
24 standards of care that you were involved with?

25 A Yes.

1 Q And forgive me for being crass because I really  
2 don't know what happened. It's my understanding  
3 that you had a falling out, for lack of a better  
4 word, with the organization at some point after  
5 Version 5 was released?

6 A Can I fill you in on the details?

7 Q I was going to say please feel free to use  
8 different words than I used.

9 A Yes. I wouldn't use the words "falling out."

10 Q Okay.

11 A I presented -- we presented the fifth version, the  
12 draft of the fifth version of standards of care to  
13 the executive committee. And the president of the  
14 executive committee was the only one on the  
15 committee who took umbrage at one thing in our  
16 standards of care, and that is our requirement that  
17 two independent mental health professionals should  
18 recommend or see the patient before hormones were  
19 given. He was outraged at this, and he vowed in  
20 front of the executive committee that while he  
21 appreciated our work in general and he liked the  
22 standards of care, he didn't like that, and he  
23 found it so offensive that he was going to  
24 immediately appoint a new committee. And in 2001  
25 or 2002, pretty much the 21 pages of our standards

1 of care were identical to the new standards of  
2 care, the 6th version, but the 6th version had one  
3 letter of recommendation required for hormones.  
4 And in 2002, I believe I attended the  
5 every-two-year meeting of Harry Benjamin Society,  
6 and this time the audience was filled with  
7 cross-dressed men, trans-identified men. And  
8 during the plenary sessions, if they heard  
9 something they didn't like, they booed. And this  
10 was, in my view, a scientific organization. We're  
11 all trying to figure out from the '70s what in the  
12 world was going on here and what should the medical  
13 professional do about it. And if we, in fact, gave  
14 prisoners or patients what they wanted, what would  
15 be the outcome? And so these were the major  
16 questions that we were trying to figure out as an  
17 international group.

18 But when the patients were in the audience and  
19 when they booed, I -- when Dr. Green, who was the  
20 chair -- who was the head of Harry Benjamin Society  
21 in 1999, when he alone objected to this and used  
22 his power to redesign the 6th Standards of Care, I  
23 realized that the organization that I thought was a  
24 scientific organization had become an advocacy  
25 organization. And it was very hard to give a talk

1 knowing that if you said something that raised  
2 questions about the motives and the wisdom of  
3 surgery or hormones for certain people, the  
4 audience would boo.

5 And so the combination of my basic notion that  
6 this was a -- my naive notion that this was a  
7 scientific organization and it, in fact, had become  
8 in the years I had been there a -- gone from that  
9 kind of organization to an advocacy for sex  
10 reassignment surgery -- that's how we called it in  
11 those days -- that I wasn't sure that the science  
12 or knowledge base enabled us to be an advocacy  
13 organization. And so I'm basically a fellow who is  
14 always trying to figure out what is the nature of  
15 this, and what is the nature of that. And I  
16 recognized that there's a difference between  
17 scientific inquiry and advocacy, and so I -- what  
18 you called my falling out was a resignation in 2002  
19 or 2003. I just didn't pay my dues and so --

20 Q So you terminated your membership in WPATH?

21 A I just -- right. I stopped going.

22 Q Have you been a member of WPATH since that time?

23 A No.

24 Q I'm sorry?

25 A No.

1 Q Okay. Okay. Doctor, I'm looking for just the  
2 two-sentence version here, but in general, what is  
3 gender dysphoria?

4 A Gender dysphoria is an interpretation of one's  
5 psychic pain that's based on the fact that I have a  
6 gender identity that doesn't match my body.

7 Q You agree that it is a diagnoseable mental health  
8 disorder?

9 A Yes.

10 Q Okay. And it's listed as such in the current  
11 version of the Diagnostic and Statistic Manual Of  
12 Mental Disorders, the DSM-5, and its text  
13 provision?

14 A Yes.

15 Q Okay. And it's my understanding that both the  
16 DSM-5 and the DSM-TR identifies several criteria  
17 for the diagnosis of gender dysphoria, is that  
18 correct?

19 A Yes.

20 Q And in your clinical practice, are these the  
21 criteria that you apply in order to determine  
22 whether to diagnose someone with gender dysphoria?

23 A Well, that's a bit of a joke, actually. The  
24 patient comes in with a diagnosis. You see, when  
25 people come in with pain in their abdomen, the

1 doctor diagnoses the source. The patient doesn't  
2 come in and say, I have an infected gallbladder,  
3 Doctor, or I have diverticulitis. But in these  
4 cases, a person comes in and says, I have gender  
5 dysphoria. And so we just ascertain, you know, has  
6 it been there for six months? Does it cause any  
7 impairments in your social, educational, or  
8 occupational functioning? Do you want to have --  
9 do you want to have the body parts of the opposite  
10 gender? Do you dislike your primary and secondary  
11 sexual characteristics? Do you feel like you have  
12 the feeling your subjective world is much more  
13 close to the opposite gender?

14 Q Is it fair to say that they come in and say, hey, I  
15 have this problem, and at that point, it's your job  
16 to determine if they meet the clinical criteria for  
17 formal diagnosis of gender dysphoria?

18 A Yeah. That's the apparent job, but what I'm saying  
19 is a bit of a joke is the patient tells you the  
20 diagnosis. And based upon our experience in the  
21 '70s and '80s and in the '90s, many people have  
22 read about the criteria for gender dysphoria, and  
23 they tell us -- they tell us that they meet the  
24 criteria in their narrative. You don't know, but  
25 in the 1970s, the doctor wanted to distinguish the

1 true transsexual from what was called the secondary  
2 transsexual, and then we discovered after about 10,  
3 15 years --

4 Q Doctor, I'm so sorry. We have gone a little far  
5 from where the question --

6 A No, we haven't. No, we haven't.

7 Q Doctor, my question was when a patient comes in the  
8 door and says, hey, I think I have this problem,  
9 it's your job or the clinic's job to determine if  
10 they meet the clinical criteria for formal  
11 diagnosis of gender dysphoria, is that correct?

12 A And it is whether they're telling the truth.

13 Q Okay. So, yes, it is your job to decide if they  
14 meet the clinical criteria, is that correct?

15 A And if they're telling us the truth.

16 Q Okay. I just -- and the only problem here is  
17 because there's a court reporter writing this down,  
18 Doctor, but the answer to my question is, yes,  
19 that's the clinic's responsibility, and it's also  
20 their responsibility to determine if the patient is  
21 telling the truth, is that correct?

22 A Yes.

23 Q I'm sorry?

24 A That's correct.

25 Q Okay. And in determining whether a person carries

1 a clinical diagnosis of gender dysphoria, I assume  
2 you apply the criteria in the DSM-5 or its text  
3 revision?

4 A Yes.

5 Q Okay. And you agree that self-report can be  
6 helpful in diagnosing many mental health  
7 conditions, is that fair?

8 A Yes, can be helpful.

9 Q Okay. Do you agree that if not properly treated,  
10 gender dysphoria can cause a patient significant  
11 distress?

12 A The question is what is proper treatment?

13 Q I understand that, but the question presupposes  
14 that the patient is not being properly treated. Do  
15 you agree that if not properly treated, gender  
16 dysphoria can cause a patient significant distress?

17 A The question is meaningless because we have a  
18 disagreement about what is the proper treatment.  
19 So I can answer that question yes and you could  
20 interpret it this way, and I interpret it quite the  
21 opposite way.

22 Q Doctor, I understand that we might have the  
23 disagreement on what proper treatment is, but do  
24 you agree in general matters that if a patient with  
25 gender dysphoria is not receiving proper treatment,

1       however you define that term, the condition can  
2       cause the patient significant distress?

3               MR. CARLISLE: I'm going to object to the  
4       argumentative nature of the questioning. The  
5       doctor is trying to answer. Counsel cut him off.  
6       Please let him finish the question. He's trying to  
7       answer. These are complicated questions you're  
8       asking.

9       Q Do you understand the question, Doctor?

10      A I understand the question has a built-in ambiguity  
11      that would skew anyone's interpretation of the  
12      answer to that question. So the proper treatment  
13      sometimes could be no treatment. Sometimes it  
14      could be psychotherapeutic treatment. Sometimes it  
15      could be the administration of psychiatric  
16      medication, so what I'm saying is if you would ask  
17      me the same question by delineating your concept of  
18      proper treatment, I could answer the question, but  
19      as it now stands, it's too ambiguous for me.

20      Q Let me ask it this way. Do you agree there are  
21      circumstances in which gender dysphoria can cause a  
22      patient significant distress?

23      A Gender dysphoria for many people is a distressing  
24      situation. It is not a distressing -- well, again,  
25      gender dysphoria we're now talking about as a

1 diagnosis. And if we're talking about gender  
2 dysphoria as a diagnosis, the answer to your  
3 question is it is associated with distress.  
4 Whether it's treated or not treated, it is  
5 associated with distress. But if we use the term  
6 transgender, a transgender-identified person, that  
7 may -- that person may or may not have distress.  
8 And so the treatment of a transgender person who  
9 gets no treatment other than recognition that  
10 you're a transgender person, that doesn't cause  
11 distress. That's -- there are transgender people  
12 who don't want treatment who don't feel they have a  
13 problem and who are not distressed and then meet  
14 criteria for gender dysphoria.

15 Q For a transgender patient with a diagnosis of  
16 gender dysphoria who is experiencing distress, do  
17 you agree that there are treatments that can assist  
18 in alleviating that distress?

19 A Yes.

20 Q Okay.

21 MR. ROSE: I'm going to go off the record for  
22 just a second, Gretchen.

23 (A discussion was held off the record.)

24 Q Okay. Doctor, I'm pulling up for you what I have  
25 marked as Exhibit 32, and I will just ask you

1 generally first whether you recognize this  
2 document.

3 A I do.

4 Q And I will tell you that I have removed your CV  
5 from the report that Mr. Carlisle sent to us, but  
6 other than that, you recognize this as the expert  
7 report that you submitted in this case?

8 A Yes.

9 Q And did you draft this report yourself?

10 A Yes.

11 Q Okay. Did anyone other than you draft any portion  
12 of the report?

13 A No.

14 Q Other than the State's attorneys in this case, did  
15 anyone comment or make suggestions on the report  
16 before it was finalized?

17 A No.

18 Q I'm sorry. I couldn't hear you.

19 A No.

20 Q Okay. All right. And you have a hard copy of this  
21 report in front of you, correct?

22 A Correct.

23 Q And are you comfortable relying on the hard copy as  
24 we go through some questions which will allow me to  
25 bring other exhibits up on the screen?

1 A Sure.

2 Q Okay. Will you flip to pages 14 and -- 14 to 15, I  
3 suppose.

4 A Okay. Give me a second.

5 Q You're fine.

6 A I'm on page 14.

7 Q Okay. And I guess spanning pages 14 and 15, you  
8 identify six parameters that you would use for  
9 assessing the safety and efficacy of  
10 gender-affirming surgery, is that correct?

11 A Yes.

12 Q I want to go through a couple of these one by one.  
13 I don't know that my questions are going to cause  
14 you to want to look at your report or not. You  
15 should certainly feel free to if you need to do so,  
16 but the first parameter you identify is the impact  
17 on genital dysphonia, correct?

18 A Correct.

19 Q And how were you defining genital dysphonia?

20 A I don't like -- we're talking just about males now,  
21 okay?

22 Q Okay.

23 A So I don't like the presence of my penis, my  
24 scrotum, and the contents of my scrotum. And I  
25 don't like to look at them, or they disgust me, or

1 I would wish to be rid of them. And sometimes  
2 people express this by using terms like "down  
3 there," right, than specifically designating the  
4 word "penis," so --

5 Q Is it fair to say that for a transgender woman,  
6 genital dysphonia is the distress associated  
7 specifically with having a penis, scrotum, or  
8 testes?

9 A Yes.

10 Q Okay. And do you agree that in the right person,  
11 genital affirmation surgeries can cure genital  
12 dysphonia?

13 A I hope so. I think that's one of the major reasons  
14 or justifications for doing the surgery.

15 Q Okay. And I think you indicate in your report that  
16 the literature indicates satisfaction rates are  
17 generally from 72 percent to 92 percent, is that  
18 correct?

19 A Yes. But, you see, that term, "satisfaction rate,"  
20 doesn't ever get clarified too explicitly. I'm  
21 presuming, and based upon what the literature is  
22 presuming, that when it comes to genital dysphonia,  
23 I hope that the satisfaction rates means I'm happy  
24 not to have these organs on me any longer.

25 Q But the initial dissatisfaction generally reflects

1 surgical complications?

2 A Well, yes, in the immediate, you know, one, two,  
3 three weeks after a surgery, I would imagine that  
4 first not having the genitals, the male genitalia,  
5 is a source of satisfaction, and then having  
6 female-appearing genitals, even though you can't  
7 see them because of bandages, that's a source of  
8 satisfaction. Then the dissatisfaction comes from  
9 the experience of pain, but most importantly when  
10 they actually see their genitals, that if there's a  
11 problem with that, then they get dissatisfied that  
12 they don't have adequate-looking female genitalia.

13 Q And is it fair, Doctor, to say that the surgical  
14 complications, in your understanding, can range  
15 from extremely mild to more severe?

16 A Yes.

17 Q And minor complications can oftentimes be treated  
18 easily with over-the-counter medication or  
19 something like that to reduce symptoms such as  
20 nausea or headaches or something like that?

21 A No. I wasn't thinking about that, no. I was  
22 thinking about anatomical matters. Postoperative  
23 care with antibiotics or nausea medicine or pain  
24 medicine, that goes without saying, is just part of  
25 postoperative care. Those aren't complications.

1 Nausea from an anesthetic, for example, is not --  
2 that's not what I consider to be a complication or  
3 what surgeons consider to be a complication. It's,  
4 you know, the turning black of a new tissue.  
5 That's a surgical complication, you know, the --  
6 for -- I just want to distinguish between ordinary  
7 postoperative distress, pain, discomfort, and  
8 nausea, sometimes the horror at the amount of blood  
9 that's being in the bandages, these are not  
10 complications.

11 Q My understanding is that there's an established  
12 system for rating surgical complications and their  
13 severity. Are you familiar with that?

14 A Not very, no.

15 Q Okay.

16 A There's what the surgeons call minor versus major  
17 complications.

18 Q Have you ever heard of the Clavien-Dindo scale?

19 A No.

20 Q For the court reporter, that's two words,  
21 C-l-a-v-i-e-n, and the second word is D-i-n-d-o.  
22 Doctor, just for the record -- and I'm sorry. I'm  
23 trying to cross things off here. You're not a  
24 physician, is that correct?

25 A I'm not a physician? That's not correct. I am a

1 physician.

2 Q I'm sorry. You're not a surgeon, is that correct?

3 A I'm not a surgeon.

4 Q In paragraph 36 of your report, you cite a study  
5 with a complication rate, I think, of 28.9 percent.  
6 You agree that rate includes what you will call  
7 minor complications?

8 A I'm sorry. I'm trying to find the sentence. It's  
9 on page 16?

10 Q I'm sorry. It's on the very bottom of page 15 in  
11 the 2018 study of 330 patients.

12 A Oh, yes.

13 Q You agree that the complication rates reported  
14 there reflect minor complications, correct?

15 A Right now I don't know if the satisfaction -- I  
16 don't know if that's total complication rate or the  
17 minor complication rate without looking at the  
18 article.

19 Q Okay.

20 A I presume it's the total complication rate.

21 Q Some of the articles that you cited rate  
22 complications as a grade Roman numeral I, grade  
23 Roman numeral II, Roman numeral III. Are you  
24 familiar with that rating system?

25 A No. Actually, the term that you used that you

1 spelled out for the court reporter, I have never  
2 encountered that in the articles that I have read.  
3 That's why I said I never heard of it. So if it is  
4 a standard, it's certainly not a standard in the  
5 articles that I read.

6 Q Okay. And are you familiar in general matters with  
7 complications being assigned a grade level followed  
8 by a Roman numeral?

9 A No, but that would make sense to me.

10 Q Do you believe that the articles that you cited  
11 used that grade system?

12 A I don't think so, but I cited a lot of articles,  
13 you know, read them a long time ago so...

14 Q Okay. Will you flip to paragraph 40 of your  
15 report? Let me know when you're there.

16 A I'm there.

17 Q In this paragraph, you provide what you call an  
18 edited abstract from -- a quotation from an edited  
19 abstract from an article published by Dunford and  
20 others, is that correct?

21 A Yes.

22 Q And by edited, I assume that you edited certain  
23 portions of the quotations that you used?

24 A Yes, just to make it more succinct.

25 Q Okay. I'm going to try to share my screen once

1       again. I'm going to pull up what I have marked as  
2       Exhibit 33. Do you see that in front of you?

3       A Yes. Could you raise the font?

4       Q I have absolutely no idea -- I can try to zoom.

5       A I'm sorry. It's just -- I'll read it the way it  
6       is.

7       Q Okay. I found a way to zoom in. I'm sorry.  
8       There. Is that better?

9       A Yes. Thank you.

10      Q Okay. My first question is do you recognize this  
11      Exhibit 33 as the Dunford article that you cite?

12      A Correct.

13      Q Let me know if you need me to scroll down.

14      A Okay.

15      Q Do you recognize this as the Dunford article that  
16      you cite?

17      A Yes.

18      Q And on the first page of this article, I have  
19      highlighted a portion of the abstract that happens  
20      under -- the sub-header is emphasis and  
21      conclusions. Did you have an opportunity to read  
22      the highlighted portion?

23      A You're not talking about the abstract now, right?

24      Q We're still in the abstract, yes.

25      A Oh, under -- I'm sorry. The conclusions, yes.

1 Okay.

2 Q I'm sorry. Yeah. The sub-header under the  
3 abstract.

4 A I misunderstood your question. All right. "The  
5 evidence for gender reassignment surgery  
6 complications and functional outcomes is of the low  
7 level."

8 Q Doctor, let me just -- I'm sorry. Let me take you  
9 where I was going with that. My question to you is  
10 you agree that the highlighted portion of the first  
11 page here is the portion from which you provided an  
12 edited quotation in paragraph 40 of your report?

13 A Yes.

14 Q Okay. And the portion you just read said the  
15 evidence for GRS complications and functional  
16 outcomes is of low level, correct?

17 A Yes.

18 Q And it's my understanding that the phrase "low  
19 level" has an established meaning in scientific  
20 research. Is that a fair statement?

21 A That's correct.

22 Q The highest level evidence is evidence from  
23 randomized clinical trials, double-blind studies,  
24 stuff of that nature, is that fair?

25 A Systematic reviews of large numbers of articles,

1       yeah.

2       Q   And you agree that something like a randomized  
3       controlled study cannot ethically be performed to  
4       determine to meet the efficacy of gender-affirming  
5       surgeries, is that fair?

6       A   Well, this is a highly debatable question, and it  
7       involves intricate methodologic consideration. And  
8       given, you know, your time constraints and you're  
9       not willing to have me sort of give a discourse on  
10      things, I don't think I can answer your question  
11      affirmatively that it's fair. It's complicated.  
12      There could be random assignments to surgery, to  
13      not surgery. And for a one-year followup, a  
14      two-year followup, and the people who didn't get  
15      surgery after the designated period of time, if  
16      they still wanted to, could have surgery. So I  
17      think it's -- what we're up against is that many  
18      people feel based upon the fashion of doing surgery  
19      that it's medically necessary, and it's helpful,  
20      and therefore they say it's not ethical to withhold  
21      effective treatment.

22               But as you can tell from the rest of my expert  
23      opinion report, the question about whether the  
24      benefit on the mental health of a person which is  
25      the whole reason for doing these operations, that

1 the answer to that question is certainly not clear  
2 after 60 years of doing surgery. So I do believe  
3 it's possible, but there is no will to do ethical  
4 things, but the reason it's not done is not because  
5 it's unethical. It's not done because there's no  
6 will to do it. Surgeons want to do surgery, and  
7 patients want to have surgery. And so the answer  
8 becomes we can't answer the question in a  
9 scientific way.

10 Q So you think it would be ethical to withhold  
11 surgery from persons that a surgeon might think  
12 would benefit from the surgery?

13 A If the field after 50 years in a high level way  
14 cannot determine the benefits, the fact that a  
15 surgeon thinks that a patient would benefit is not  
16 as compelling as the fact that science hasn't  
17 demonstrated there's a consistent benefit from  
18 doing this.

19 Q My understanding is that evidence called low level  
20 technically refers to evidence from descriptive or  
21 qualitative studies or retrospective studies  
22 perhaps with a very small sample size, is that  
23 fair?

24 A What that really means is you can't be sure. If  
25 the evidence is of low level, low grade level, then

1 we can't be sure that the harms don't outweigh the  
2 benefits or that we can -- the benefits cannot be  
3 guaranteed. That's what low level means. If it  
4 says very low level, what that means is that the  
5 harms may distinctly outweigh the benefits. If  
6 it's a low level, we can't be sure that the  
7 benefits that are aspired to be achieved will be  
8 achieved. That's what low level means in a  
9 specific sense.

10 Q And you agree that scientists and practitioners  
11 rely on the level of evidence from time to time,  
12 correct?

13 A Ideally.

14 Q And it's my assumption that if one low level study  
15 is performed and then another low level study  
16 reaches the same conclusion, that a number of low  
17 level studies can add up to something that has  
18 greater significance to practitioners than any  
19 single study, is that fair?

20 A Yes. But, again, the evaluation of a group of  
21 studies cannot be done by simply -- if it's a  
22 surgical study, for example, it can't simply be  
23 done by surgeons. It has to be done by people who  
24 are much more sophisticated about scientific  
25 methodology. You see, I want my surgeon to be an

1 expert as to how to do the surgery. That doesn't  
2 necessarily -- that expertise which I assume they  
3 have is not the same as the expertise in the  
4 scientific review of, say, 35 studies on the  
5 subject. Those are two different skill sets, and  
6 most surgical training programs do not train  
7 surgeons on methodologic evaluation of data.

8 Q Okay. And flipping back to paragraph 40 of your  
9 report, are you still there?

10 A Still there.

11 Q The first underlined sentence that you have there  
12 says, "The evidence for complications and  
13 functional outcomes is low and weak." Do you see  
14 that?

15 A Yes.

16 Q So it's my understanding that in editing this  
17 abstract, you changed the words "of low level" to  
18 be simply "low and weak", is that correct?

19 A Is of low level. You mean I added in "weak"?

20 Q You added in "weak" without noting that you changed  
21 the verbiage in the article, yes.

22 A Well, but I guess I did. I didn't realize I did.  
23 But, of course, that's what low level means.

24 Q Okay. Doctor, I would just tell you that because I  
25 don't want to waste your time going through the

1 article at any length, you are absolutely correct  
2 that this Dunford article characterizes most of the  
3 research, most of the studies on this subject, as  
4 being of low level. It does, however, characterize  
5 one study of being of moderate level. Do you have  
6 an understanding as to what it means for a study to  
7 be of moderate level?

8 A I don't think moderate is the term that is used.  
9 Maybe -- wait a second. It probably means of  
10 likely benefit.

11 Q Okay.

12 A But moderate means without certainty, I think.

13 Q Okay. And I will just tell you that this study  
14 describes as being moderate level a study performed  
15 by Buncamper and others that was published in 2016,  
16 which I have brought up as Exhibit 34 on your  
17 screen.

18 A Uh-huh.

19 Q Do you see that in front of you?

20 A Very -- yeah.

21 Q I can scroll down here. Do you see that now?

22 A Yes.

23 Q Are you familiar with this study?

24 A Not right off the bat, no.

25 Q Okay. Are you aware that the study was cited

1 multiple times in the SOC8?

2 A No.

3 Q This study describes itself as a retrospective  
4 study. What is a retrospective study?

5 A It means looking backwards. It means the -- it's  
6 the opposite of a prospective study. A prospective  
7 study we evaluate the patient by certain  
8 psychometric or certain objective terms and  
9 subjective terms, and then we do periodic future  
10 reevaluations using the same patterns, using the  
11 same instruments. And then we, at a predesignated  
12 time, say, two years or five years, we look at the  
13 comparison between the pre- and the postoperative  
14 state and make conclusions.

15 So a retrospective study doesn't have any of  
16 the pre -- it's just after the surgery is done, we  
17 then take a look at how the patients are faring  
18 hopefully both objectively and subjectively that is  
19 how they report they're doing.

20 Q Okay. In the conclusions in the study, the authors  
21 write, and I'm quoting here, that -- the portion I  
22 have highlighted on your screen spanning pages  
23 1,006 to 1,007 they write, "After reviewing 475  
24 penile and vaginoplasty procedures performed over  
25 the past 14 years, we conclude that successful

1 vaginal construction is achieved in the majority of  
2 patients without the need for a secondary  
3 functional reoperation. Intraoperative  
4 complications are scarce. The prevalence of  
5 postoperative complications is high but most are  
6 minor and can be easily treated."

7 Did I read that correctly, Doctor?

8 A Yes. You're an excellent reader, Mr. Rose.

9 Q And my assumption is that intra, i-n-t-r-a,  
10 operative complications are those that arise during  
11 the surgery itself?

12 A Or -- yeah, that would be like bleeding.

13 Q Sure. And that's distinguished from postoperative  
14 complications which arise after the surgery?

15 A Yes, and divided into first 30 days with up to 6  
16 months, 1 month to 6 months and then 12-month  
17 complications.

18 Q Do you agree that 475 patients over the span of 14  
19 years is a decent sample size?

20 A Oh, yes. You see -- yes, certainly.

21 Q And before today were you aware of this article?

22 A I don't know.

23 Q Is there a reason that you did not mention it in  
24 your expert report?

25 A Probably because if it's not in my report, it's --

1 I'm not aware. As I think I said to you, if you  
2 put in PubMed "vaginoplasty," you get 11,000  
3 articles and --

4 Q Well --

5 A It's one of the many thousands of articles I  
6 haven't read.

7 Q And that's certainly understandable. I will  
8 readily admit I have not read every legal decision  
9 out there, but Exhibit 33, the Dunford article, you  
10 did cite in your report characterizes exactly one  
11 study as being of moderate level rather than being  
12 low level, and I was wondering why you did not take  
13 it upon yourself to find a moderate level evidence.

14 A Maybe I was lazy, and maybe I was rushing. I don't  
15 know. You need to understand that retrospective  
16 studies done by surgeons -- I don't know whether --  
17 you see, I don't know how many people died, how  
18 many people suicided. This is talking about the  
19 surgical complication rates. It's not talking  
20 about anything else. It's not even talking about  
21 whether -- about genital dysphonia or gender  
22 dysphoria or mental health. It's just saying that  
23 from a retrospect of 475 operations done by most  
24 likely a series of surgeons over a 14-year period,  
25 generally speaking, the -- and we have this term

1 "scarce," which is a very unusual term for a  
2 surgeon to use. We usually use "the surgical  
3 complication rates were low." I don't know, you  
4 know, what -- or they say it's 5 percent or less.  
5 I have tried to quote surgical articles and give an  
6 actual percentage rate. And so if 9 percent -- if  
7 9 percent of people have to have a second major  
8 operation, you know, a rescue operation, you can  
9 decide whether 9 percent it means -- is scarce.  
10 It's not about this article.

11 The other thing is if the vast majority of  
12 articles show inconvincing evidence and if one  
13 shows convincing evidence, what do we make of that?  
14 You see, in science, one study is not enough to  
15 prove anything. One study is enough to generate a  
16 hypothesis that needs to be tested.

17 Q Okay. Doctor, the second parameter that you cite  
18 beginning on paragraph 41 of your report, is the  
19 impact of gender dysphoria. Do you see that?

20 A Oh, yes.

21 Q And when you use the phrase "gender dysphoria,"  
22 here are you using it consistent with how it is  
23 defined in the DSM?

24 A Yes, about the sense of living in one's body in a  
25 way that causes distress.

1 Q And are you referring to it here as a clinical  
2 diagnosis, gender dysphoria, I guess was my  
3 question?

4 A I'm sorry. Would you repeat that, Mr. Rose?

5 Q Are you referring to it here as the clinical  
6 diagnosis, gender dysphoria?

7 A No. I'm suggesting that gender dysphoria has two  
8 different meanings. One is -- it's a psychiatric  
9 diagnosis, yes or no, and the other thing is it is  
10 the subjective discomfort with the self because I  
11 want to be a woman, for example, and I don't feel  
12 completely feminine. So it's the continued  
13 dissatisfaction with the gendered and anatomic  
14 self. And I know this is confusing, but the  
15 treatment is not of the diagnosis. The treatment  
16 is justified on the basis of the diagnosis, but the  
17 goal of treatment is to remove or significantly  
18 ameliorate the subjective gender dysphoria of  
19 living in a body that doesn't match my gender  
20 identity and ambition to be much more -- appearing  
21 more much more a woman so I can feel more  
22 comfortable with my sense of self and my living in  
23 my body, and that's just the confusion between the  
24 terms.

25 Q Is it fair to say here that you're using the term

1 "gender dysphoria" to refer to a symptom rather  
2 than that clinical diagnosis?

3 A Yes.

4 Q Okay. And you agree that gender-affirming  
5 surgery -- excuse me -- that genital affirmation  
6 surgery can ameliorate a patient's gender dysphoria  
7 to the extent the gender dysphoria is focused on  
8 the genitals, is that correct?

9 A That's why I say the high satisfaction rates may  
10 very well be about the absence of male genitalia.

11 Q And I'm sorry. I might have just missed the first  
12 word to your answer, but did you say yes?

13 A Yes. I was clarifying my answer.

14 Q That's perfectly fine. I just didn't hear you.  
15 I'm sorry. And you agree other types of  
16 affirmation surgery can ameliorate a patient's  
17 gender dysphoria to the extent their gender  
18 dysphoria is focused on those other body parts, Is  
19 that fair?

20 A Yes. Ameliorate means improvement. Do we agree on  
21 that meaning? It can lessen the -- it can lessen.

22 Q Yeah, of course. In paragraph 43 of your report,  
23 you identified five types of observations that  
24 suggest that gender dysphoria persists after gender  
25 confirmation surgery for an unknown number of

1 patients. Do you see that?

2 A Yes.

3 Q I have a question about a couple of these, but the  
4 first is that some seekers obtain additional  
5 surgery. Do you see that?

6 A Uh-huh.

7 Q Is that yes?

8 A Yes. I'm sorry.

9 Q That's for the court reporter, not me. And this  
10 might be because the persons who have one type of  
11 gender confirmation surgery such as genital surgery  
12 might continue to experience dysphoria related to  
13 other body parts, is that correct?

14 A Yes.

15 Q Okay. It's possible that the person always planned  
16 to have surgeries in sequence such as they always  
17 planned on the second surgery?

18 A That's -- I guess it's possible, but that's not my  
19 usual experience. The usual experience, especially  
20 with prisoners, is that they say, this is the only  
21 thing I want.

22 Q Okay. The second observation you note is that some  
23 persons detransition after a vaginoplasty. A small  
24 number will ask the surgeon to re-create the  
25 appearance of male genitalia. Do you see that?

1 A Yes.

2 Q And the study you cite there is a 2016 study by  
3 Djordjevic and and others, is that correct?

4 A Yes.

5 Q For the court reporter, that's D-j-o-r-d-j-e-v-i-c.

6 A That's J.

7 (Exhibit 35 was marked for identification.)

8 Q Oh, did I say G? I'm sorry. D-j-o-r-d. Thank  
9 you. Okay. I am bringing up what I have marked as  
10 Exhibit 35. Do you see that on the screen?

11 A Yes.

12 Q Do you recognize this as the Djordjevic study that  
13 you cite?

14 A Yes.

15 Q And on the first page, I have highlighted a portion  
16 of it. Under aims, the author describes that the  
17 aim is to analyze retrospectively seven patients  
18 who underwent reversal surgery after regretting  
19 their decision to undergo male-to-female sex  
20 reassignment surgery elsewhere. Do you see that?

21 A Yes.

22 Q All right. Okay. Is it fair to say that this  
23 study did not attempt to determine anything about  
24 the rate of regret?

25 A No, they couldn't.

1 Q And that's because they were only analyzing persons  
2 who had already decided that they wanted reversal  
3 surgery, correct?

4 A Right. This study is significant only in the fact  
5 that there are people who regret having sex  
6 reassignment surgery who go so far as to find  
7 another person to restore their male genitalia.  
8 That's the only significance of the study.

9 Q So you only cited this to note that some persons  
10 have in fact requested reversal surgery, is that  
11 fair?

12 A (Inaudible.)

13 Q I'm sorry, Doctor. I might just be having  
14 difficulty hearing. Did you yes?

15 A I said that's all, yes.

16 MR. CARLISLE: Gavin, I'm sorry to interrupt.  
17 Could you zoom in on the next exhibit just for me?  
18 I'm have a little trouble seeing the screen.

19 MR. ROSE: On this exhibit?

20 MR. CARLISLE: No, on the next one.

21 MR. ROSE: Of course. And I don't think we're  
22 quite there yet, and all of these are published in  
23 the tiniest font possible, and that's not my fault.

24 Q Okay. Doctor, I'm looking at paragraph 44 of your  
25 report. Do you see that?

1 A Uh-huh.

2 Q Yes?

3 A Yes.

4 Q I'm sorry. And the third sentence in that  
5 paragraph you write, "One illuminating criticism,  
6 for example, is that to qualify as regret a person  
7 has had to tell the surgeon this at a follow up  
8 visit even though it is known that at least  
9 75 percent of detransitioned patients do not return  
10 to the surgeon and that suicides are not considered  
11 to be regret."

12 Did I read that correctly?

13 A Yes.

14 Q And the article you cite for that is an article  
15 published in 2021 by Littman and -- or I guess just  
16 by Littman, is that correct?

17 A Yes.

18 Q And I have pulled up Exhibit 36 on your screen.  
19 Can you see that okay?

20 A Yeah, I can see it.

21 Q Sorry. I'm trying to remember where the zoom  
22 button is.

23 A Okay.

24 Q This is the Littman article that you cite, is that  
25 correct?

1 A Yes.

2 Q Are you're familiar with Dr. Littman?

3 A Yes.

4 Q And you're aware that she was responsible for  
5 coining the term quote, unquote, rapid onset gender  
6 dysphoria to refer to gender dysphoria diagnosed  
7 for a first time during a patient's adolescence?

8 A I think the simple answer to your question is yes.

9 Q And you agree that that term, rapid onset gender  
10 dysphoria, has been sharply criticized by a large  
11 number of professional organizations including the  
12 American Psychological Association and the American  
13 Psychiatric Association?

14 A And I'm aware the outcome of those things too that  
15 the study was reanalyzed, and it was reaffirmed  
16 only when advocates of -- well, see, in 2018 --

17 Q I'm sorry. Doctor, I don't mind that you're  
18 explaining, but I didn't actually get an answer to  
19 my question. The question was simply you  
20 understand that a large number of professional  
21 organizations sharply criticized Dr. Littman's use  
22 of that term, correct?

23 A And the answer is yes, and I'm aware that as a  
24 result of -- I don't know if it's a large number --  
25 but there were organizations that criticized the

1 study, and it caused the data to be reanalyzed, and  
2 the conclusions were exactly the same.

3 Q And by this reanalysis, do you mean that  
4 Dr. Littman published a correction to her original  
5 article?

6 A I think so, yeah.

7 Q During this correction, a portion of her correction  
8 was designed to make it clear that some of the data  
9 she obtained from publishing a poll or survey on  
10 websites that some persons thought might be biased?

11 A Yes. But bias goes both ways, and it is amazing in  
12 this field there is such animus and such attack  
13 that has not seen in any other medical field. And  
14 Dr. Littman has been the object of enormous attacks  
15 over the years, as have many other people who don't  
16 seem to buy the fashion-based medicine party line,  
17 and so this is --

18 Q Doctor, in paragraph 44, you cite this Littman  
19 article, Exhibit 36, for two propositions, first,  
20 that at least 75 percent of detransitioned patients  
21 do not return to the surgeon who performed the  
22 confirmation surgery, and, second, that suicides  
23 are not considered to be regret. Is that a fair  
24 summary of these statements for which you are  
25 relying on this article?

1 A Yeah. But the second idea is not the same as the  
2 first. They are two different concepts.

3 Q But you, as you sit here today, cite this Littman  
4 article, Exhibit 36, for both of those concepts,  
5 correct?

6 A No. The suicide rates are not considered regret.  
7 I guess I should have -- I should have put the  
8 Littman citation after the word "surgeon."

9 Q Okay. So you cite this for the proposition that it  
10 is known that at least 75 percent of detransitioned  
11 patients do not return to the surgeon?

12 A Based on the Littman review of those 100 cases.

13 Q Okay. And it's my understanding that Dr. Littman  
14 in this article reviewed survey answers from 100  
15 respondents who described themselves having quote,  
16 unquote, detransitioned?

17 A Yes.

18 Q So it again was not attempting to determine regret  
19 rate, is that fair?

20 A No. It can't determine rate on the basis of the  
21 method she used.

22 Q Okay.

23 A It's the same kind of concept that we talked about  
24 for the surgical, previous exhibit.

25 Q Do you believe that the article was attempting to